World Physiotherapy
Europe region

Report on the survey on Professional Autonomy in the national health care system in the Europe region

Advocacy and European Matters Working Group (A&EUMWG)

NOTED
19th and 20th May 2022
Prague, Czech Republic

REPORT ON THE SURVEY ON PROFESSIONAL AUTONOMY IN THE NATIONAL HEALTH CARE SYSTEM IN THE EUROPE REGION

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CONTENTS

1. BACKGROUND

Based on the recommendation approved by the General Meeting of 2018, and reconfirmed by the General Meeting in 2020, and also in line with the Strategic Objective 2 of the Europe region Strategic Plan, the Advocacy and European Matters Working Group (A&EUMWG) gathered specific information to identify physiotherapists' autonomy that is legally permitted in the member organisations' national health care system (NHCS). The data derived from the survey could be used as a benchmark for all the Member Organisations (MOs). Through the benchmark, the Europe region could assist MOs that want to take actions targeting specific aspects identified through the survey.

The results of the second survey were analysed during the summer of 2021. Before sending it out, the survey was updated based on the feedback gathered in a discussion session in October 2020 and discussions in the A&EUMWG meeting in January 2021. The updated survey followed the basic structure and questions of the first survey. It was updated with additional qualitative questions in order to better understand the insights of the autonomy in MOs. Also, the introduction emphasised that the questions target the **legal** framework of autonomy for physiotherapists working in the **public system** of a member organisation.

2. AIM OF THE SURVEY

To update the information on physiotherapists' autonomy that is permitted by law in the national health care system of each Member Organisation.

3. OBJECTIVES OF THE SURVEY

The objectives of this survey were to:

- specify markers indicating physiotherapists' professional autonomy;
- identify the countries in which a medical prescription is required to access physiotherapy services within the NHCS;
    - to understand the content of the medical prescription, in the NHCS where it is required;
- identify the countries in which referral procedures are required to access physiotherapy services within the NHCS;
    - to understand how the patients are referred to physiotherapy services;
- identify the countries where it is legally permitted for physiotherapists to assess the patient within the NHCS;
- identify the countries where it is legally permitted for physiotherapists to diagnose the patient within the NHCS;
- identify the countries where it is legally permitted for physiotherapists to refer to other health care professionals within the NHCS;
- identify the countries where it is legally permitted for physiotherapists to refer to diagnostic tests and X-Ray within the NHCS; and
- identify the countries where it is legally permitted for physiotherapists to prescribe medications within the NHCS.

- understand the subjective satisfaction of physiotherapists' professional autonomy as felt by the representative of a MO
- specify markers on which developments are mostly desired in order to increase the level of autonomy.

4. METHODOLOGY

A survey was created with the programme SurveyMonkey. A first invitation was e-mailed to 39 countries (37 MOs plus France and Poland) on May 17th, 2021. On May 27th , 2021 a gentle reminder was e-mailed to support a high response rate. On June 7th, 2021 a second gentle reminder was sent to seven MOs. On June 13th, 2021 a final reminder was sent to the four remaining countries that had not responded to the previous emails. By July 6th, 2021, 38 of 39 countries had responded, resulting in a 97% response rate.

Results were collated per question and per member organisation. Out of the 38 responding MOs 23 (61%) replied to all questions. The remaining 15 (39%) provided either incomplete answers to questions or answers that were contradictory to other answers provided. During July and August 2021, those 15 countries were contacted via e-mail to ask for clarifications. By the end of September 2021 all answers were clear and complete. The one remaining country was contacted again in October, 2021 in order to support a 100% response rate, however no answer was received.

In order to complete the report, the A&EUMWG decided to use the updated answers.

The members of the A&EUMWG planned to conduct short follow-up interviews with the MOs. After receiving the answers and doing the preliminary analysis, the plan was cancelled.

5. RESULTS

The detailed results of the survey will be provided in the appendices. In this section a general overview of the spectrum of answers to each question of the survey is provided.

1) **Medical prescription**

   Fourteen MOs (37%) reported that medical prescription is always necessary to access physiotherapy services and eighteen MOs (47%) reported that medical prescription is needed under certain circumstances. The circumstances mentioned varied a lot and include amongst others: health care sector (needed only in public sector), patient's diagnosis (needed only for certain diagnosis), physiotherapist's qualification (not needed when physiotherapist has a certain qualification). See Appendix 3 for more precise information. Six MOs (16%) reported that medical prescription is not necessary to initiate physiotherapy. See also Appendix1, infographic A.

   In the previous survey 71% of the MOs reported that medical prescription was necessary to access physiotherapy services and 29% of the MOs stated that physiotherapy could be initiated without medical prescription.

2) Contents of the medical prescription

Looking at the MOs that require a medical prescription (29; 100%), 26 (89.7%) stated that the *medical diagnosis* is included in the prescription. *The number of treatment sessions* is reported by 16 of the MOs (55.2%) as content of the mandatory prescription. The *area to be treated* is included on the prescription in 15 MOs (51.7%). The *physiotherapy treatment type* is included on the prescription in 10 MOs (34.5%), and the inclusion of *frequency of treatment* in the prescription is reported by 9 MOs (31%).

Out of the 38 MOs (100%), 9 (31%) reported that prescription only contained 1 specification. *Medical diagnosis* was reported as the sole component in the prescription by 8 MOs (27.6%) and the *area to be treated* was reported as the sole component in the prescription by 1 MO (3.4%). A total of 4 (13.8%) stated that two of the possible prescription specifications are included. Four MOs (13.8%) reported that three specifications are included on the prescription. Three MOs (10.3%) indicated that four specifications are included on the prescription. All specifications are included on the prescription of 7 member organisations (24.1%). Two MOs (6.9%) have not reported the specifics contained in the medical prescription required to initiate physiotherapy. See also Appendix 1, infographic B.

In the previous survey 22% of the MOs reported that the necessary prescription only included medical diagnosis and 22% of the MOs stated that all specifications were included on the prescription.

3) Possibility to adapt the specifics of the medical prescription

The specifics of the prescription can be adapted in consultation with the prescriber in 7 MOs (29%), while another 8 MOs (33%) reported that the specifics can be adapted without consulting the prescriber. A total of 4 member organisations (17%) replied that the prescribed treatment is at the sole responsibility of the physiotherapist. Five MOs (21%) reported other situations, like differences between legal requirements and actual practice. See also Appendix 1, infographic C, and Appendix 3.

In the previous survey 37% of the MOs stated that the specifications of the prescription could be adapted in consultation with the prescriber, 30% of the MOs reported that the prescription could be adapted without consulting the prescriber and 37% of the MOs reported that the prescribed treatment is at the sole responsibility of the physiotherapist.

4) Why is the medical prescription needed in the public system?

According to the MOs, the medical prescription is required to have access to physiotherapy services (24; 82.3%) and to have the physiotherapy services reimbursed (21; 72.4%). Sixteen MOs (55.2%) reported that medical prescription is required for both reasons. See also Appendix 1, infographic D.

The reasons for the requirement of the medical prescription were not assessed in the previous survey.

5) Referral to physiotherapists

Eleven MOs (18%) of the 38 MOs reported that patients can always self-refer to a physiotherapist. Twelve MOs (19%) reported legally authorised self-referral for patients in specific situations, such as in schools for children with special needs, emergency or protocolized situations, for guidance and counselling, in MSD advanced scope of practice and preventive care.

Thirty-one MOs (49%) described that medical doctors can refer patients to physiotherapy-services and nine MOs (14%) reported that medical doctors and other health professionals can refer to physiotherapy. See also Appendix 1, infographic E.

In the previous survey 21% reported that patients could always self-refer to the physiotherapist.

6) Legal authorisation to asses and diagnose

Nineteen MOs (50%) reported that physiotherapists are legally authorised to assess and diagnose. The legal authorisation to assess a patient but not to diagnose was reported by another 13 member organisations (34.2%). Six MOs (15.8%) stated physiotherapists are not legally authorised to assess or diagnose a patient. See also Appendix 1, infographic F.

In the previous survey 45% of the MOs reported that physiotherapists were legally able to assess and diagnose and 8% stated that physiotherapists were not authorised to assess or diagnose patients.

7) Referral from a physiotherapist

Fourteen MOs (36.8%) indicated that physiotherapists are legally able to directly refer patients to a general practitioner. Moreover, 8 MOs (21.1%) reported that physiotherapists have the legal possibility to directly refer patients to a medical specialist, while 9 MOs (23.7%) stated that direct referral to another health care professional is legally authorised. Six MOs (15.8%) stated that physiotherapists are legally able to refer a patient to X-Ray and 4 MOs (10.5%) stated physiotherapists have the legal authority to refer a patient for other diagnostic tests (e.g. MRI). See also Appendix 1, infographic G.

In the previous survey, the permission to directly refer patients to a general practitioner was reported by 42% of the MOs and 21% of the MOs stated that physiotherapists were allowed to directly refer patients to a medical specialist. Another 18% of the MOs reported that direct referral to another health care professional was legally authorised.

8) Prescription of medication by a physiotherapist

One MO (2.6%) reported that physiotherapists are legally authorised to prescribe medication as a part of their treatment. See also Appendix 1, infographic H.

In the previous survey one MO reported the legal authorisation to prescribe medication.

9) Satisfaction with the legal level of autonomy for physiotherapists

Eighteen MOs (47.4%) have graded their satisfaction with the legal level of autonomy in the public system with 5 points or more (mean: 4.5) on the scale from 1 to 10. None of the MOs were fully satisfied with the level of autonomy. Two MOs chose 9 as the most suitable indicator of their satisfaction, five MOs picked 1.

Among the MOs grading their autonomy level with 4 or less points, the aspects of professional autonomy that those MOs like to see improved were mainly related to direct access, the ability to refer to other health professionals, the ability to prescribe diagnostic procedures (e.g., X-Ray, US), the ability to make a diagnosis and to the improvement of the educational system.

The MOs grading their autonomy level with 5 or more points would like to see improvement in the ability to refer patients to other healthcare services, the ability to prescribe diagnostic procedures and the ability to prescribe selected medication and medical devices. See also Appendix 1, infographic I, and Appendix 3.

The satisfaction with the level of autonomy and the aspects of professional autonomy that the MOs would like to see improved was not assessed in the previous survey.

6. LIMITATIONS

The limitations of the survey acknowledged are:

- The Language barrier: the survey was conducted in English which it is not the first language of the majority of the Member Organisations;
- The differences of the terminology used in the National health care systems of the member organisations;
- The individual respondent bias which may not be reflective of the national picture;
- Comparisons with the results of the previous autonomy survey must be conducted carefully as the respondents may have not been the same and changes may not indicate a true change in professional autonomy and;
- The public system may not be representative of the level of autonomy of physiotherapists working in the private sector and may not be the most representative for many MOs.

7. CONCLUSION

This survey is a follow-up of the physiotherapy professional autonomy survey issued in 2019, updated with qualitative questions improving the insights on the autonomy level in the different MOs, and emphasising that the questions target the legal framework of professional autonomy in the public system of an MO.

The survey results draw attention to the specific elements related to professional autonomy that need attention in each MO, and the Europe region is ready to assist the MOs, if so desired,

in the journey to improve professional autonomy. Moreover, the data can be used by the Europe region to advocate for the physiotherapy profession in Europe. Furthermore, it is possible to assess the evolution of each MO, comparing the results in both surveys. However, caution is needed when interpreting the differences between surveys, as differences may be attributed to the fact that different persons have answered the surveys and not to real changes in the professional autonomy level.

8. RECOMMENDATIONS

A regular (bi-annual) update of the data is advised, allowing to keep track of the evolution of professional autonomy within the MOs of the Europe region. For the next survey, the Working Group advises to consider tracking the reasons for contradictory results, i.e., asking about recent changes. Continuing the same core questions, would allow for highlighting and charting trends that are happening within Europe regarding professional autonomy of physiotherapists.

9. ACKNOWLEDGEMENTS

The Europe region acknowledges and thanks the Advocacy and EU Matters Working Group members involved in the development of this 2022 report: Michele Cannone (Italy), Petra Dubajova (Slovakia), Kadri Englas (Estonia) (lead), Adérito Seixas (Portugal) and Gabriella Szendro (Hungary).

10. APPENDICES

Appendix 1 – Infographic A to Infographic I (separate annex 19.1.)

Appendix 2 – Responses of member organisations from 2022 and 2020 (separate annex 19.2.)

Appendix 3 – Definitions and Frequently Asked Questions (FAQs)

Appendix 3

10.3 DEFINITIONS

- A **referral** can be defined as a process in which a health worker at one level of the health system, having insufficient resources (drugs, equipment, skills) to manage a clinical condition, seeks the assistance of a better or differently resourced facility at the same or higher level to assist in, or take over the management of, the client's case *(WHO, 2020)*.

- **Prescribing** is defined as issuing prescriptions for the medical treatment of a single individual by an 'appropriate practitioner' *(Charted Society of Physiotherapists, 2016)*

- A **prescription** can be defined as a written instruction by an appropriate practitioner *(Charted Society of Physiotherapists, 2016)*.

- An **assessment** can be defined as the evaluation of the health status and the formulation of the associated needs for professional help, by performing a physical exam after taking a health history.

- A **diagnosis** is the determination of a disease or condition explaining a person's symptoms and signs. One or more diagnostic procedures, such as (medical) tests and assessment are often done to substantiate the result.

Frequently Asked Questions

- **What is a regulated profession?**
  A profession is said to be regulated when access and exercise is subject to the possession of a specific professional qualification *(European Union Commission, n.d.)*.

- **What is a health system?**
  Health systems are responsible for delivering services that improve, maintain or restore the health of individuals and their communities. This includes the care provided by hospitals and family doctors, but also less visible tasks such as the prevention and control of communicable disease, health promotion, health workforce planning and improving the social, economic or environmental conditions in which people live. Health systems are also responsible for the careful management (or stewardship) of these services to ensure that they reach everyone equally, are responsive to individual needs and vulnerabilities, and do not impose an excessive financial burden on individuals or families *(WHO, 2020)*.

- **What is a National Health system?**
  Health systems in EU Member States are varied, reflecting different societal choices. However, despite organisational and financial differences, they are built on common values, as recognised by the Council of Health Ministers in 2006 universality, access to good quality care, equity and solidarity *(European Commission, 2014)*.

All health systems in the EU aim to make provision, which is patient-centered and responsive to individual need. However, different Member States have different approaches to making a practical reality of these values: they have, for example, different approaches to questions such as whether individuals should pay a personal contribution towards the cost of elements of their health care, or whether there is a general contribution, and whether this is paid for from supplementary insurance. Member States have implemented different provisions to ensure equity: some have chosen to express it in terms of the rights of patients; others in terms of the obligations of healthcare providers. Enforcement is also carried out differently — in some Member States it is through the courts, in others through boards, ombudsmen etc. It is an essential feature of all our systems that we aim to make them financially sustainable in a way which safeguards these values into the future *(European Council, 2006)*.

Country profiles are accessible at: https://ec.europa.eu/health/state/country_profiles_en

- **What is the difference between the public health care system and the private health care system?**

  Within the political and institutional framework of each country, a health system is the ensemble of all public and private organizations, institutions and resources mandated to improve or restore health. Health systems encompass both personal and population services, as well as activities to influence the policies and actions of other sectors to address the social, environmental and economic determinants of health *(WHO Europe, 2012)*.

  A unifying principle of public health is its essentially “public” nature and the fact that it is mainly focused on the health of the whole population. Public health can be understood as a key aspect of the wider health system and can play an important role in improving the effectiveness and efficiency of health system delivery *(WHO Europe, 2012)*.

  The health system (led by the Ministry of Health) is central to public health leadership and services. Thus, public health is also about health systems, and reciprocally, health systems can only be effective if they include a strong public health services component *(WHO Europe, 2012)*.

  In the health area, the private sector refers to all non-state actors involved in health: profit and not-for-profit, formal and informal, domestic and international. Almost all countries have mixed health systems, with goods and services provided by the public and private sector, and health consumers requesting these services from both sectors. The private sector’s involvement in health systems is significant in scale and scope and includes the provision of health-related services, medicines and medical products, financial products, training for the health workforce, information technology, infrastructure and support services *(WHO, 2020)*.